



## GRIEVANCE PHONE RESOLUTION LETTER

[Date]

[Member's Name]

[Address]

[City, State, Zip]

HWLA Member Identification #: *[insert number]*

DMH ID #: *[insert number]*

Dear [Member]:

This is in response to your [date] grievance about [describe grievance]. Thank you for bringing your concern to our attention.

DMH Patients' Rights has worked with <name of facility and/or title of person> to investigate your grievance. As we talked about on the telephone, we have reached the following resolution:

<state findings>

<state conclusion and result, i.e. this is what will happen>

We value you as a HWLA member. Your concerns help us to monitor the services provided and to improve care for all of our members.

If you have questions or concerns, please contact [insert name], DMH Patients' Rights at (213) 738-4949.

**NOTE:** If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

---

*(Name of Patents' Rights Advocate)*

c: Requesting Provider/Clinic/CAU